Fraud in School-based Programs funded by Medicaid

by

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What this presentation covers

- Types of investigations
- Overview of statutes & regulations
- Requirements for School-based providers
- Covered services and expenses
- Sources of complaints
- Complaint review process
- How a Medicaid investigation is conducted
- OIG/MPI authority to obtain records
- Referrals for enforcement

Medicaid Preliminary Investigations

The primary purpose of the Medicaid Preliminary Investigations Branch of the Division of Audits & Investigations is to investigate allegations of fraud, waste and abuse in the Medicaid program by Medicaid providers.

Medicaid Preliminary Investigations

907 KAR 1:671

- **When to conduct a Medicaid Preliminary Investigation;**
- **Who is responsible for conducting Medicaid Preliminary Investigations; and**
- **Who is responsible for conducting full Medicaid investigations**

Medicaid Preliminary Investigations

Secondary responsibilities include investigating:

1. Cardsharing; and
2. Non-Emergency Medical Transportation (NEMT) cases

Criminal Statutes Relating to Provider Fraud

KRS 194A.500(4)

Defines a '**Provider**' as "an individual, corporation, association, facility, or institution that is providing or has been approved to provide medical assistance to recipients under the Medical Assistance Program."

Types of Medicaid Providers

- Hospitals
- Physicians
- Dentists
- Advanced Registered Nurse Practitioners
- Nursing Facilities
- **Schools**
- Transportation Providers
- Durable Medical Equipment Companies
- Pharmacies

To name but a few.

SCHOOL-BASED PROVIDERS

A school district that requests to participate as a school-based health care provider shall not be qualified to provide school-based health services:

- **(a) Until it has enrolled as a Medicaid provider pursuant to 907 KAR 1:672;**
- **(b) Until it has been certified by the Department of Education to provide school-based health services; and**
- **(c) Unless it is currently compliant with the Medicaid provider participation requirements established in 907 KAR 1:671.**

  - **From 907 KAR 1:715. School-based health services**

SCHOOL-BASED PROVIDERS

A Medicaid school-based health services provider shall:

- (a) Submit to an annual review by the Department of Education to ensure compliance with the standards for continued participation as a Medicaid provider;
- (b) Have an on-site survey completed by the Department of Education as necessary to determine compliance with the Medicaid Program;
- (c) Take action as specified by the Department of Education to correct a deficiency if found to be in noncompliance with the provision of services outlined in 707 KAR 1:320 or this administrative regulation;
- (d) Agree to implement a quality assurance program approved by the Department of Education for the provision of Medicaid-covered services within one (1) year from the date the Department of Education recommends enrollment to the Medicaid Program;

SCHOOL-BASED PROVIDERS

A Medicaid school-based health services provider shall:

- (e) Maintain a current list of school-based health services that the school district provides;
- (f) Maintain records on each SBHS recipient who receives services reimbursed by Medicaid. The records shall:
  - 1. Identify the child, services performed, and quantity or units of service;
  - 2. Be signed and dated by the professional who provided or supervised the service;
  - 3. Be legible with statements written in an objective manner;
  - 4. Indicate progress being made, any change in treatment, and response to the treatment; and
  - **5. Be retained for a minimum of five (5) years** plus any additional time required by law; and
- (g) Comply with 907 KAR 1:671 and 1:672.

COVERED SERVICES & EXPENSES

The following services shall be covered if provided to address a medical or mental disability and to assist an individual in benefiting from special education programming which is included, authorized, and provided in accordance with the individualized education program (IEP):

- (a) Nursing;
- (b) Audiology;
- (c) Speech and language;
- (d) Occupational therapy;
- (e) Physical therapy;

COVERED SERVICES & EXPENSES

The following services shall be covered if provided to address a medical or mental disability and to assist an individual in benefiting from special education programming which is included, authorized, and provided in accordance with the individualized education program (IEP):

- (f) Behavioral health services;
- (g) Incidental interpreter services provided in conjunction with another covered service;
- (h) Orientation and mobility services;
- (i) Respiratory therapy;
- (j) Assistive technology devices and appropriate related evaluations if the devices purchased by the Medicaid Program become the property of the SBHS recipient; and
- (k) Special transportation with (certain) limitations.

Criminal Statutes Relating to Provider Fraud

KRS 194A.505(6)

No person shall, with intent to defraud or deceive, devise a scheme or plan a scheme or artifice to obtain benefits from any assistance program by means of false or fraudulent representations or intentionally engage in conduct that advances the scheme or artifice.

Criminal Statutes Relating to Provider Fraud

KRS 194A.990§4-6(b) – Penalties associated with violations of KRS 194A.505

- Class D felony or Class C felony if over $10,000
- Repay all payments to which provider was not entitled
- Three times the amount of payments to which provider was not entitled
- Reimburse expenses related to enforcement of 194A.505

RELEVANT STATUTES & REGULATIONS

KRS 194A.505(3) – Prohibition against cardsharing or unauthorized use of medical identification card

No person shall, with intent to defraud, knowingly use, attempt to use, acquire, transfer, forge, alter, traffic, counterfeit, or possess a medical identification card, food stamp or food stamp identification card, or unique electronic authorization codes or numbers or electronic personal identification numbers in any manner not authorized by law.

RELEVANT STATUTES & REGULATIONS

Civil Statute Relating to Provider Fraud & Penalties

Under **KRS 205.8467(1)**, provider penalties include:

(a) Repay, with interest, payments received in violation of KRS Chapter 205

(b) Civil penalty equal to 3 times the overpayment

(c) Civil penalty of $500 for each false claim

(d) Legal fees, cost of investigation & enforcement

(e) Be removed as a Medicaid provider for specified periods

See KRS 205.8451 et seq.

Sources of Medicaid Complaints

- **The OIG Medicaid Welfare Fraud and Abuse Hotline: 1-800-372-2970**
- **Other Source Referrals (OSR)**
  - Kentucky Board of Medical Licensure
  - The Department for Medicaid Services
  - The Office of the Attorney General
  - Other Divisions within OIG (e.g., Health Care Facilities & Services)
  - SURS (Surveillance & Utilization Review System)
  - Law Enforcement (e.g., KSP)
  - U.S. Health & Human Services, OIG

Complaint Review Process

Medicaid fraud (non-eligibility) complaints are reviewed by a Medicaid Services Specialist(s)

Examples:

- Provider Fraud
- Third Party Liability (TPL)
- Medical Identification Card Sharing
- Overutilization
- Drug Seeking

Protection of Anonymity

KRS 205.8465(2) states:

"The identity of any person making a report under this section shall be considered confidential by the receiving party. Any person making a report under this section regarding the offenses of another shall not be liable in any civil or criminal action based on the report if it was made in good faith."

The Investigative Process

- Review complaint Review claims data, related procedure codes, etc. on the EDS MMIS claims system
- Find and read all relevant policy related to the issues/allegations in the complaint
- Identify & communicate with the appropriate policy & professional experts in DMS

The Investigative Process

An investigator will review the complaint & note:

- Date complaint was received
- All issues & allegations
- Any possible witnesses (e.g., provider employees, patients, etc.)
- Any sources of documentation
- Identify the time period of possible fraud

When an investigator shows up …

S/he will have a list of medical files to be requested, and after determining your facility's operating hours, will show up in person to collect them.

Provider Records

907 KAR 1:672(4) et seq.

Requires Medicaid providers to maintain documentation of the services rendered, diagnoses, medical necessity, and this documentation must be maintained for five (5) years from the latter of date of final payment or completion of investigation.

Authority to Obtain Records

907 KAR 1:672(2)(6)(b) requires providers, their officers, directors, agents, employees, and subcontractors to furnish upon demand documentation related to claims submitted to DMS for payment.

(6)(h) requires providers to permit review of all books, records, case files or a sample thereof and failure to do so may result in providers being held liable for the costs of the review, including food, lodging, and mileage.

Record Samples

In addition to obtaining a random sample of records, an investigator may also obtain:

- A targeted sample; and/or
- The records of any specific person(s) named in the complaint

Analyzing Medical Records

- Billing for services not rendered
- Records signed by providers?
- Services performed by a Medicaid provider?
- Unbundling
- Upcoding
- Records were falsified or altered?
- Unable to provide records?
- Ineligible services
- Unreimbursable services

Reviewing Claims Data

An investigator will:

- Review claims data with respect to allegation(s);
- Review claims data and identify suspicious billing patterns; and
- Review both paid AND denied claims

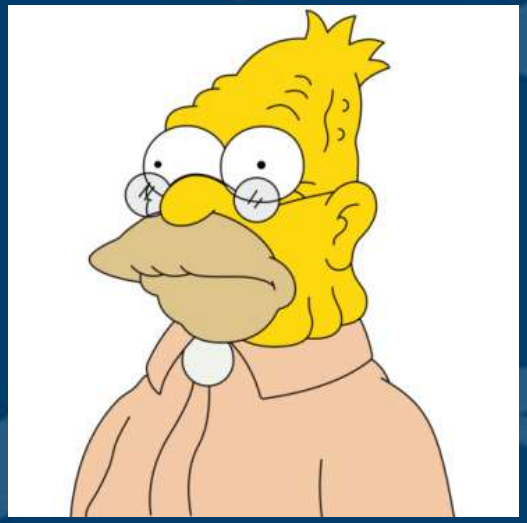
Referrals for Enforcement

All Medicaid provider cases in which there is evidence of possible criminal activity must be referred to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General.

If MFCU declines to prosecute the case, OIG may elect to submit the case to the Federal OIG or the United States Attorney.

If no law enforcement entity accepts the case for prosecution then administrative action may be taken by DMS.

Thank you.



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